

TERRITORIAL HOSPITAL, GODDARD TREATMENT CENTER
(Kaneohe State Hospital)
45-710 Kealahala Road
Kaneohe
Honolulu County
Hawaii

HABS HI-564
HABS HI-564

PHOTOGRAPHS

WRITTEN HISTORICAL AND DESCRIPTIVE DATA

HISTORIC AMERICAN BUILDINGS SURVEY
PACIFIC WEST REGIONAL OFFICE
National Park Service
U.S. Department of the Interior
333 Bush Street
San Francisco, CA 94104

HISTORIC AMERICAN BUILDINGS SURVEY

TERRITORIAL HOSPITAL, GODDARD TREATMENT CENTER (Hawaii State Hospital)

HABS No. HI-564

Location: Goddard Treatment Center
Hawaii State Hospital
45-710 Keaahala Road
Kaneohe, Hawaii 96744

UTM Coordinates: Zone: 4
Latitude: 21.405094
Longitude: -157.81576667069274

Present Owner: State of Hawaii, Department of Health

Present Occupants: Vacant

Present Use: Storage

Significance: Goddard Treatment Center is historically significant for its associations with the development of mental health practices in Hawaii. Dedicated in 1950, its 218-patient capacity was a major expansion of the Territorial Hospital and its facilities represented the latest thinking in the treatment of the mentally ill, solidifying the function of the hospital from a position of custodial care to remediation.

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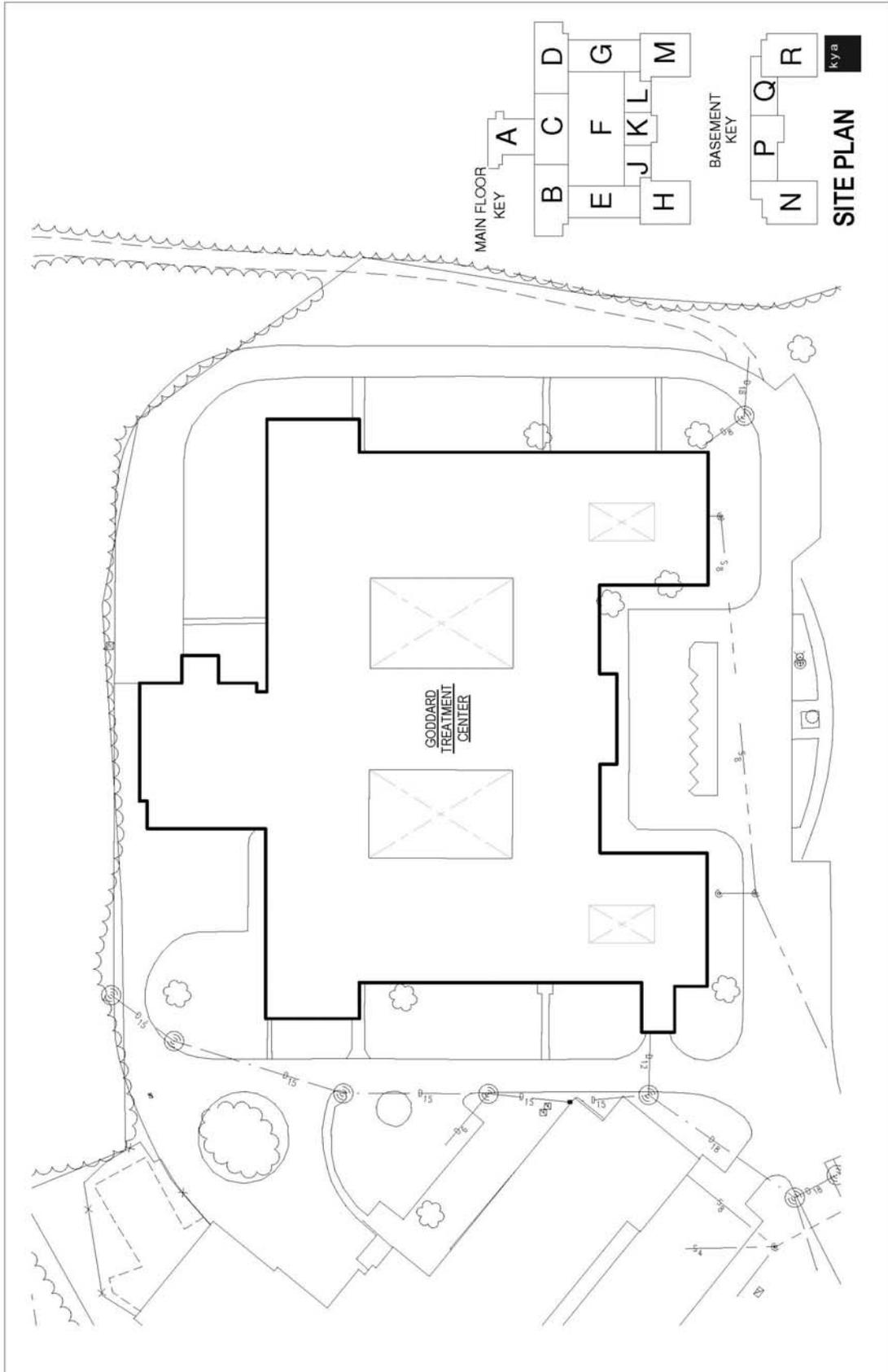


Fig. A Site Plan (Not to scale)

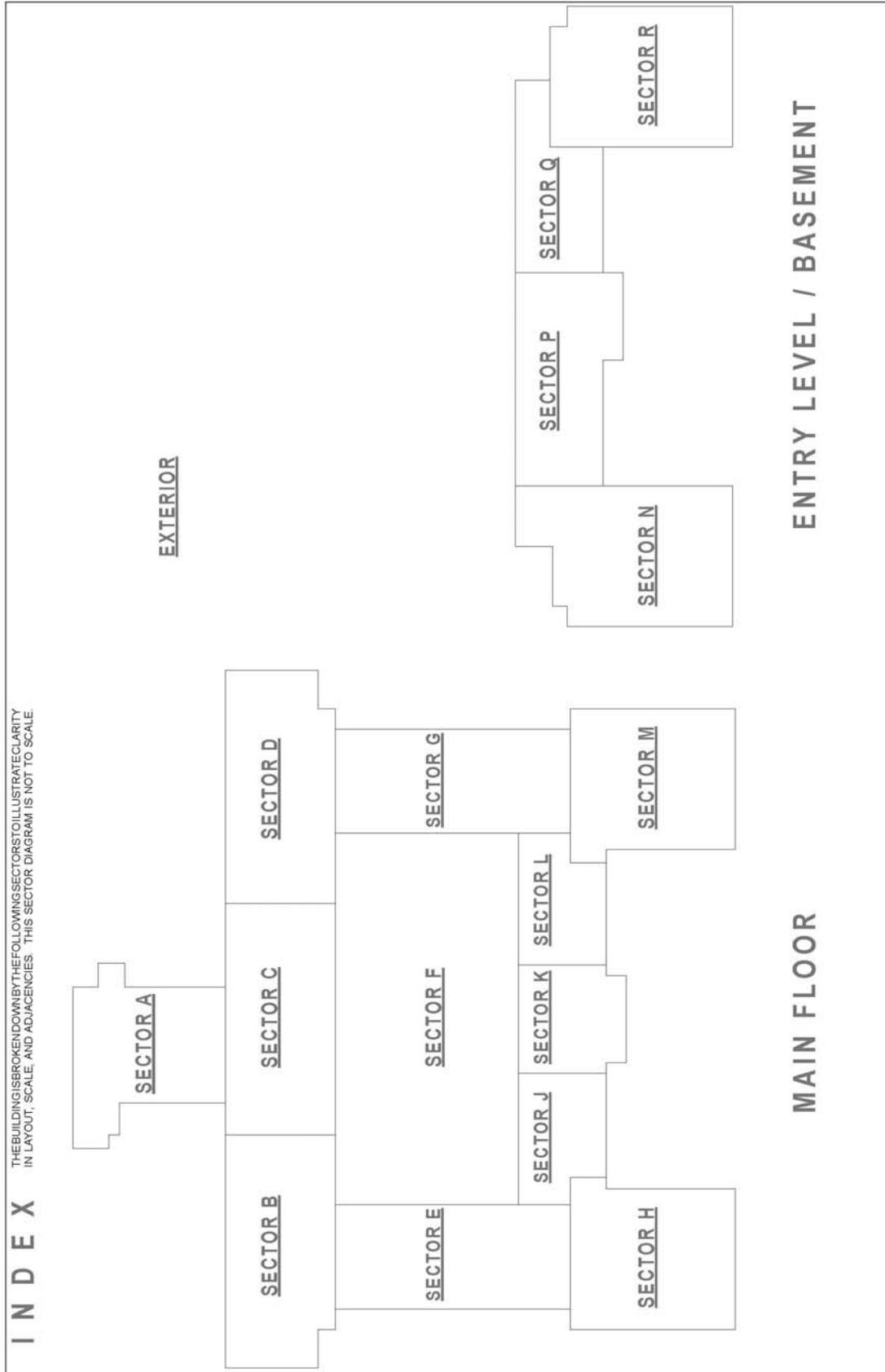


Fig. B Overall Floor Plan (Not to scale)

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Description:

The Goddard Treatment Center is a modern style, two-story reinforced-concrete building with a flat roof and 5-foot-wide, overhanging eaves. It sits on a poured-in-place concrete slab foundation and is built into the hillside at the *mauka* (towards the mountains) end of the Hawaii State Hospital campus (See *Figure A, Site Plan*). The front, *makai* (towards the ocean), portion of the building is two stories, with the second floor serving as the main floor. The building utilizes a pavilion plan (See *Figure B, Overall Floor Plan*). Its footprint measures approximately 321 feet across the front and extends back 343 feet, including a rear 79-foot by 84-foot kitchen wing. Its front wings project 67 feet from the main body of the structure. The lower story is noted as a basement on the original plans and it features a centered, entry vestibule. The basement extends back from the front of the building approximately 110 to 120 feet under the main floor.

The symmetric building is five bays wide. Each of the wings is 73 feet across and the main body of the building spans approximately 175 feet, with a centered 46-foot 4-inch-wide entry bay flanked by bays measuring 64-foot 4-inch on either side. The end walls of the wings have a center section that projects outwards 2 feet. On the first story, each wing has eight one-over-one double-hung sash windows, with three pairs in the center section and a single window at each end. On the second story, the centered section has four rectangular openings adorned by wrought iron grilles with a decorative geometric pattern of intersecting squares and diagonals. The grilles wrap around the two corners of this section. Two stacked-awning windows flank the outset section on either side. The second-story grilles in the southeast wing have been enclosed by jalousie windows.

The main body of the building features a projecting, centered entry to the building. The wall treatment for this bay differs from the rest of the building as the walls are incised with bands to give a streamlined appearance of four string courses. Three concrete steps lead up to an inset foyer which is enclosed by a pair of sliding wrought-iron gates with side panels, all similar in design to the second-story decorative grilles. The gates are flanked by cast-stone grilles depicting tropical foliage. Windows at the bottom floor are one-over-one double-hung sash, most with obscure, wire-glass lights; these are covered by wire mesh. On the second story, the entry bay features a bank of nine sets of triple-

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stacked, single-pane awning windows. To either side of the entry bay, each flanking bay's second story contains three sets of three triple-awning windows and a pair of such windows. A sidewalk runs in front of the building and is covered by a flat-roofed concrete canopy supported by round columns. The approximately 125-foot-long canopy is attached to the entry bay but free-standing at both ends. The sidewalk borders a parking area, at the far side of which is a flag pole with a battered octagonal base. The flag pole is centered on the entry.

The rear wall of the foyer is finished in an art deco manner. Its curved rear wall is adorned with five fluted Doric pilasters rendered in a modern manner. The concrete panels demarcated by the pilasters are scored to form three vertical rectangles surmounted by a horizontal one. A bronze plaque, mounted on the foyer's southeast wall, reads,

To
Oscar F. Goddard
Director of Institutions
July 1, 1939-February 9, 1944
This building is respectfully dedicated.
His vision, foresight and untiring efforts
Made possible the erection of this symbol
Of hope for those who are ill of mind.
May 20, 1950

A concrete dogleg stairway at the foyer's northwest wall leads to the main floor and the building's reception lobby. Eleven steps ascend to a landing, with another eight steps leading to the main floor. There is a wood handrail and the stairwell's wall has a wood cap. A pair of triple-stacked awning windows at the stairway's exterior walls provides illumination and ventilation.

The approximately 39-foot by 40-foot lobby is rendered in a modern manner. A *mauka-makai* axis is defined in the center of this space via the use of two dropped, concrete ceilings that form the boundaries of the space. These dropped ceilings, which cantilever approximately 2 feet beyond the

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edge of the supporting rounded columns, also house indirect lighting. The edges of the dropped ceilings are up-turned. The lower half of a Dutch door in the northwest of the lobby provides access to the former Medical Records office. A full door is mounted behind the half door to secure the room. A similar door system also gives access to the room from the lateral-running corridor on which the corner room also fronts.

At the rear of the lobby, in each of its sidewalls is a set of solid double doors with square vision panels of wire glass. The doors open on lateral-running corridors, which lead to offices and conference rooms, and then to patient rooms. The floors of the corridors have been stripped of their 9-inch-square asbestos tiles.

The southeast and northwest halves of the main floor are nearly identical mirror images of each other. These areas contain patient rooms, treatment areas, and nursing stations. The southeast half of the building was dedicated to the housing of female patients, while the northwest housed male patients.

Along the *makai* side of the lateral-running corridor on the women's side were offices of the medical director, the director's secretary, the chief nurse, occupational therapy staff, and social workers, as well as a treatment and surgical dressing room. A conference room, staff restrooms, record storage, and another secretary's office were situated on the *mauka* side of the corridor, as well as a dogleg stair leading to the basement. The *makai*-facing offices are all interconnected by internal doors and obtain ventilation and illumination from sets of triple-stacked awning windows, while the *mauka*-facing rooms have double-stacked awning windows. Corridor doors at all rooms have round vision panels, approximately 9 inches in diameter and obscure, wire-glass transoms.

On the men's side, a series of offices and conference rooms similar to those on the women's side line the lateral-running corridor. Unfortunately, plans that would reveal the functions of these various rooms have not been uncovered.

Near the end of the corridors, a pair of walkways accesses each of the building's front wings. These parallel walkways terminate at their *makai* end at a 10-foot-wide enclosed lanai whose large rectangular exterior openings are screened by

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the decorative metal grille work previously described. Each wing contains twenty-four private patient rooms which border the walks and are sited around an open, courtyard measuring 25-feet 4-inches by 37-feet 8-inches with a central, octagonal brick fountain (See *Figure C, Courtyard at Patient Wing Plan*). The fountain is approximately 17 inches high and is capped by a wooden seat. It is presently filled with dirt and debris. The courtyard is paved with the same concrete brick used in the fountain and has stone-paved "walks" leading to the fountain from each side. The courtyard is defined by two square columns and two pilasters on its sides. Three private rooms are located at each of its ends with one-over-one double-hung sash windows looking into the courtyard. The courtyard is covered with added chain-link fencing over a steel I-beam pergola, presumably in response to escape attempts.

The private patient rooms are entered from a hinged door with a six-pane window at the top and a screen transom utilizing a heavy, half-inch metal screen. Each room measures 8 feet x 15-feet 4-inches and has a one-over-one double-hung sash window in its rear wall. An extruded-metal mesh screen covers the window on the interior. Every two rooms share a common bathroom located at the front of the rooms, giving the rooms an L-shape with an entry passageway. The bathrooms have solid-core doors and include a sink, toilet, and shower. The shower has 7-foot-high salmon-colored tile walls with its entry set at an angle in the corner. A large square screened opening in the courtyard wall provides ventilation. It utilizes the same mesh screen as the transom over the door.

Mauka of the reception lobby is a large, approximately 60-foot by 90-foot-long room called a pavilion on the original plans. Two short parallel hallways run from the lobby to the pavilion. An elevator shaft and a room, originally designated a library, are situated between the two hallways. The elevator, accessed from the southeast hall, goes to the basement and its shaft serves as the back wall of the lobby, while the library opens on the pavilion. Above the library is a projection booth for showing motion pictures. A door in the northwest hallway accesses a steep, metal-ladder stair with eight treads that ascends to the projection booth. Restrooms

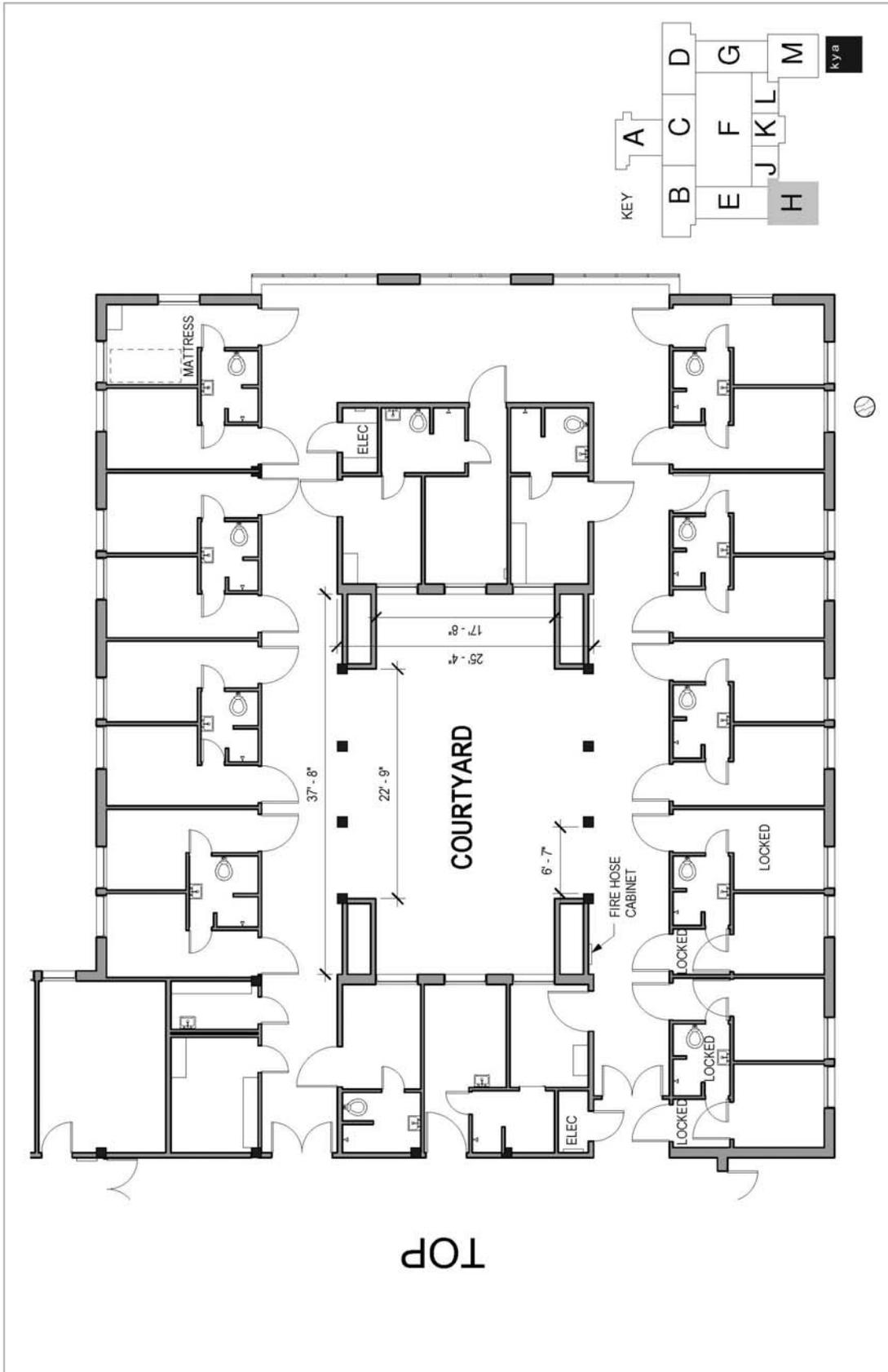


Fig. C Courtyard at Patient Wing Plan (Not to scale)

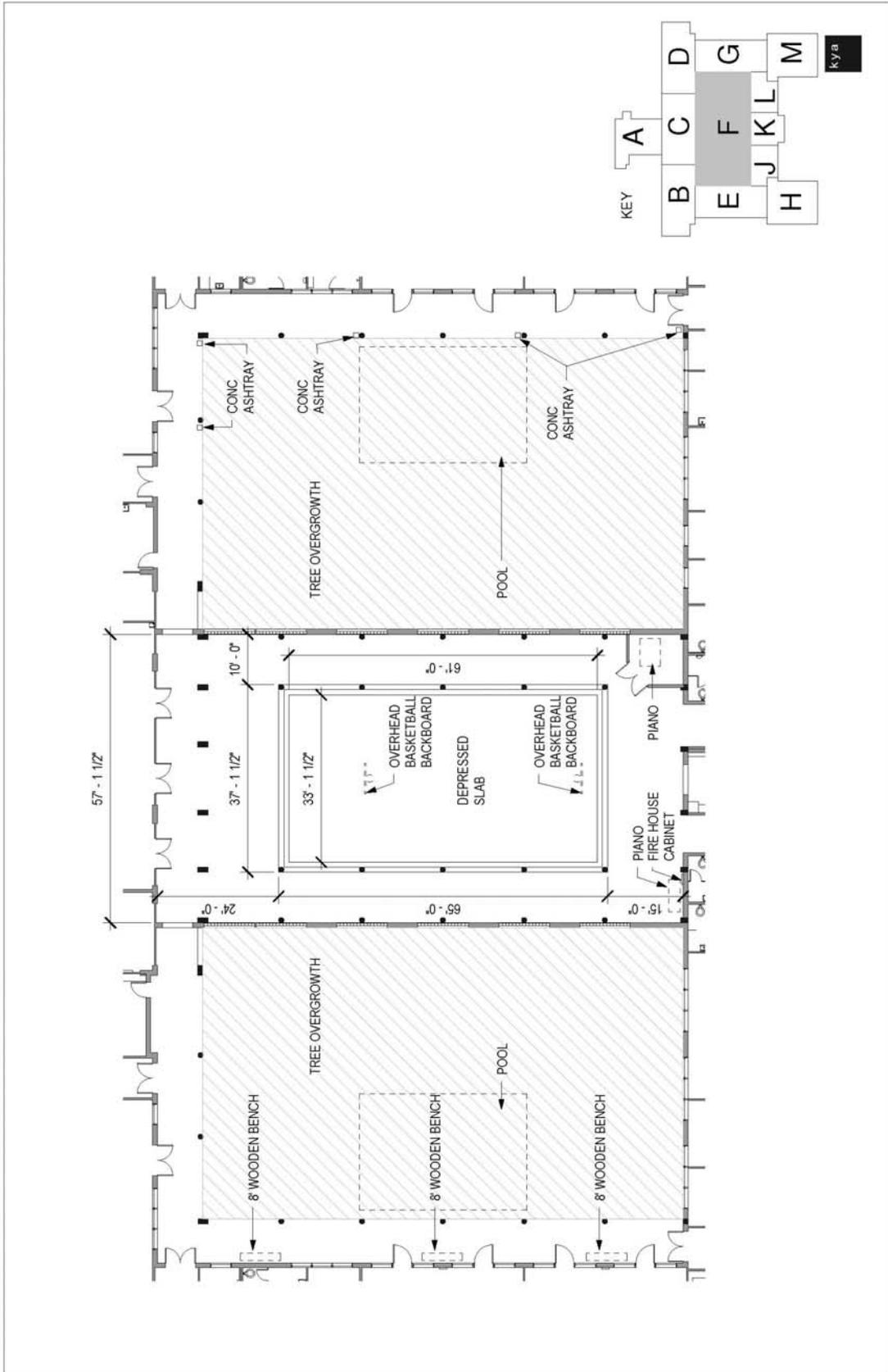


Fig. D Basketball Court Plan (Not to scale)

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are located opposite the elevator and projection booth door. Immediately *mauka* of the restrooms, double doors with rectangular viewing panels separate the lobby side of the hallways from the pavilion side.

The pavilion has a sunken, center area with a concrete floor, which is three steps down from the level of the main concrete floor. The sunken area is sheltered by a flat, monitor roof with fixed single-pane windows and wood slat ventilators in its clerestory. Basketball backboards and hoops are above either end of the sunken part of the pavilion.

The pavilion is six bays long, with each bay demarcated by the monitor roof's 6" x 12" concrete roof beams and round columns (See *Figure D, Basketball Court Plan*). The columns support the main roof and ceiling of the pavilion. The main roof runs around the perimeter of the sunken area with its monitor roof. A light bulb in a metal cage is suspended from the ceiling in each bay. Each bay contains a fixed, single-pane window flanked by wood slat ventilators in the monitor's clerestory. The end bays of the clerestory have solid panels rather than wood slat ventilators. The side wall of each bay is framed by round pilasters and is comprised of a centered double doorway, which is now sealed by plywood and is flanked by a wall with a 40-inch-high concrete base surmounted by a 40-inch-high glass block upper section. A screened transom runs above both the doorways and the walls. The doorways open on courtyards on either side of the pavilion. The 90-foot x 60-foot-long courtyards are both now completely overgrown with vegetation. Originally, they were used for outdoor recreation and included a swimming pool with tile walls, no longer readily visible. The pool was sited on the section of the southeast-side courtyard parallel to and furthest from the pavilion's side walls. Angled security fencing was later added around the perimeter of these large courtyards at roof-top level.

To the rear of the pavilion are the cafeteria and kitchen areas, with a boiler room and incinerator at the back of the building (See *Figure E, Kitchen Plan*). Two sets of double doors access the cafeteria from the pavilion. The doors have three panels; the two lower panels are solid and the top panel is screened. A set of three wood-slat jalousie windows are located to either side of the two doorways, and white-glazed ceramic drinking fountains are mounted on the

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pavilion-facing wall spaces beyond the windows. A similar drinking fountain is located in the southeast lobby-pavilion hallway opposite the elevator. Immediately to the southeast of the cafeteria is a former concession stand, which in 1975 was converted into a staff dining room, and to the northwest, a door accesses a room that formerly functioned as a beauty salon.

The cafeteria is a large open space measuring 45-feet 6-inches by 87-feet 1-inch with a series of six square reinforced concrete structural columns running laterally across the room (See *Figure F, Cafeteria Plan*). The room originally had terrazzo floors, but now it is bare concrete. The rear wall of the room has three one-over-one double-hung sash windows on its northwest side. On the southeast side is a former serving line with a roll-up door and a door that leads back to the kitchen. The kitchen has red clay tile floors and its walls feature a 6-foot 3-inch white ceramic tile wainscot. All the counters, sinks, and preparation areas are of stainless steel, as is the serving line. There are three walk-in cold storage units at the rear, which have stainless steel fronts and doors. To the kitchen's southeast side a dietician's office is in one corner. This was a new position authorized after World War II. The three windows in the side wall are one-over-one double-hung sash. The kitchen was remodeled in 1975, and the equipment and finishes date from that time.

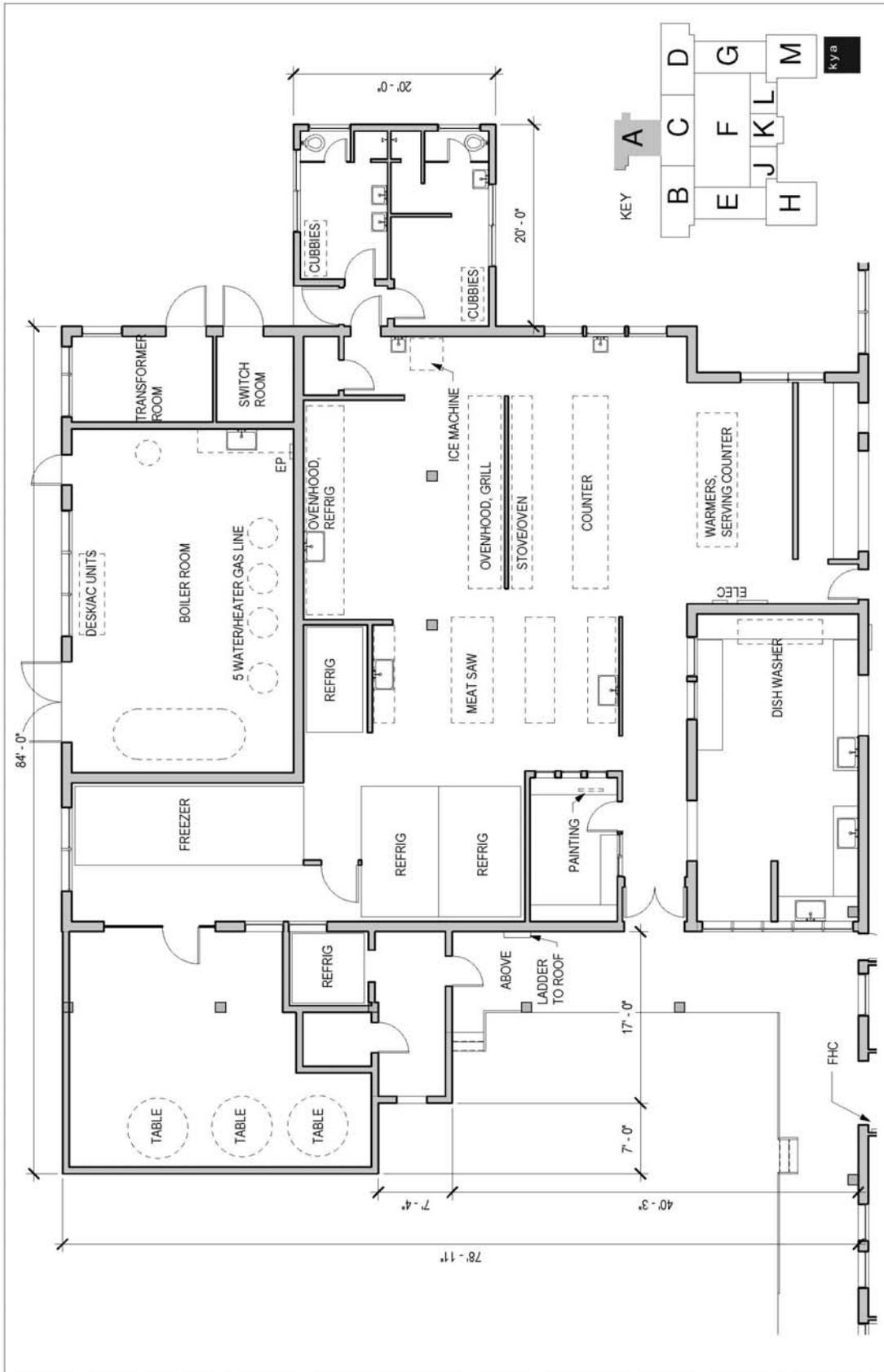


Fig. E Kitchen (Not to scale)

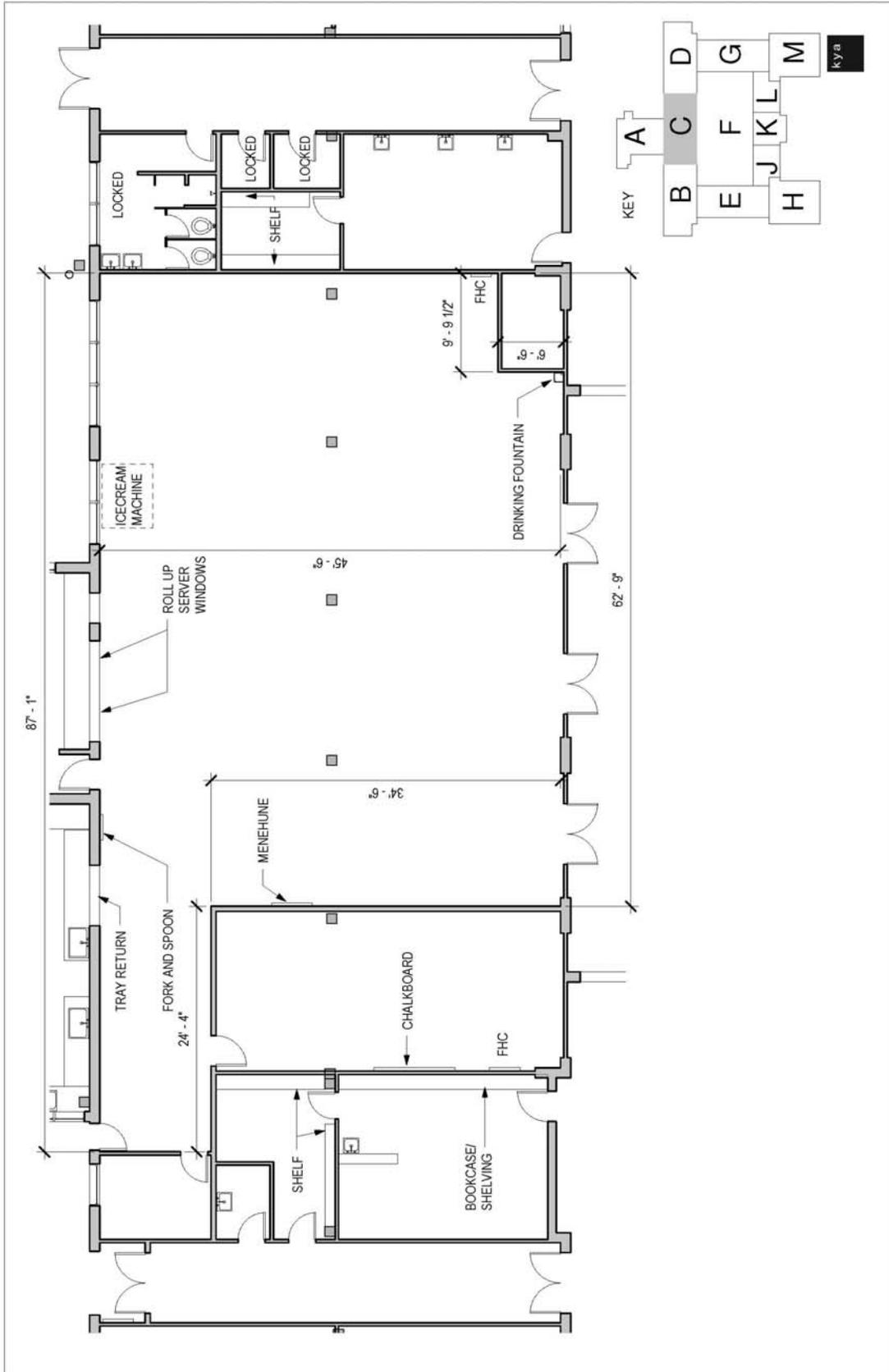


Fig. F Cafeteria Plan (Not to scale)

Parallel corridors run in a *mauka-makai* direction along the side of the former concession stand and beauty salon. These lead directly to the outside, and double doors with rectangular viewing panels are located at both ends of the corridors. The doors leading outside have wire glass transoms.

Lateral-running walkways extend in either direction from the cafeteria end of the pavilion. The concrete walkways traverse the *mauka* edges of the courtyards flanking the pavilion and are defined initially by a 39-inch-high concrete wall and then by three round columns. The colonnade continues to run down the side of the courtyard furthest from the pavilion as the walk wraps around this side of the courtyard as well.

Along each walkway on the *mauka* side, opposite the courtyard and extending beyond it, is a large room that was originally used as a 36-bed patient ward. These patient wards were later converted into dayrooms, which was their use when the building last housed patients. The two wards still remain large open spaces; however, on the women's side, two rooms were constructed with wood floor-to-ceiling partition walls in its *mauka*-northwest corner, and similarly, one such room was built in the men's ward in its *mauka*-southeast corner. These wards each have ten one-over-one double-hung sash windows in their *mauka* walls. At each end of the wall, the windows are placed in pairs and in the middle, in sets of three. Off each ward is a two-bed alcove with a single one-over-one double-hung sash window. Bathroom facilities lay immediately beyond it and patients used a short hall along the alcove's *makai* side to access the bathroom. Adjacent to the short bathroom hall is a nurses' station, and behind that is a room for the treatment of surgical dressings. Both the station and its adjoining room have solid doors.

The lateral-running corridors each terminate at the sides of the hospital. At the ends are three sets of double doors, each leading in a different direction. The set at the end of the corridor opens to the outside. The *makai* set opens on an inset lanai that runs along the side of the building, and the third, *mauka* set, accesses a short corridor that leads to the rear of the building. Originally, this set of doors accessed a hydrotherapy area of the building. The men's side remains intact, but the rooms on the women's southeast side have

been converted into a store room and two patient rooms, each of which have a one-over-one double-hung sash window with an extruded metal screen on its inside.

The inset lanai running down each side of the building measures 121-feet 6-inches long by 52-feet 2-inches wide (See *Figure G, Lanai*). The lanai has a steel railing employing an X pattern. The railing has 1-inch by 1-inch rails and the X's cross pieces are of ¼-inch by 1-inch stock. Nine round columns support the overhanging eave of the flat roof and three approximately-centered concrete steps access the lanai from the grounds. Another set of five steps provides a second access at the *makai* end. These steps are off-set from the end of the lanai by a curving concrete wall. The wall rises approximately 4 feet above from the sidewalk leading to the steps.

The hydrotherapy section on the men's side remains relatively intact. The hallway accessing this area has three rooms on its northwest side and two on its southeast side, as well as a closet at the end of the hall. The first room on the southeast contains a therapeutic pool originally used as part of the treatment regimen for patients who needed to loosen their muscles. The pool is approximately 4 feet deep, accessed by a narrow set of nine steps with a round metal handrail. The pool is approximately 12 feet long and 6 inches wide. It is lined with blue glazed ceramic tile. The room it occupies has a ceramic tile floor and salmon-colored glazed hollow tile walls up to about 7 feet high with plaster above and a plaster ceiling. The floor tiles are set in a pattern of small, offset squares surrounded by smaller rectangles, with all the tiles colored in varying earth tones. In the *mauka*, northwest corner of the therapeutic pool room is a toilet stall with gray-veined marble walls and door. A pair of chains, looped between round metal stanchions, is located along the edge of the pool to prevent someone from accidentally falling into it.

Adjoining the therapeutic pool room on the southeast side of the hallway is the room for treatment of surgical dressings, which can also be accessed from the 36-bed ward. On the northwest side of the hallway are rooms dedicated to pack treatment and continuous-flow tub treatment. The central,

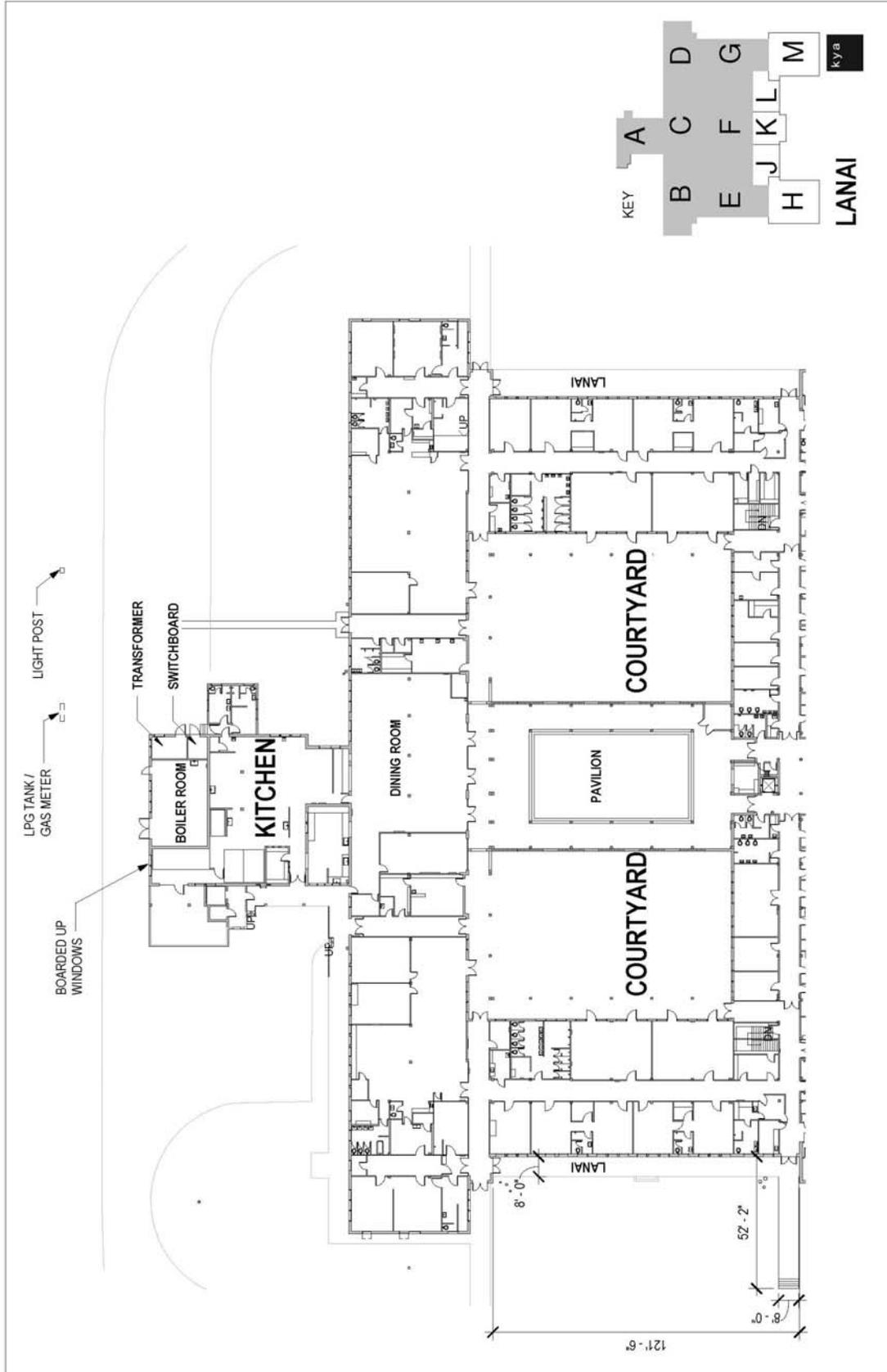


Fig. G Lanai (Not to scale)

continuous-flow tub room and the *mauka* adjoining pack therapy room both have 8-feet 6-inch-high salmon-colored glazed hollow tile walls which are surmounted by a wire mesh transom on all their interior walls. These rooms have concrete floors and have one-over-one double-hung windows in their exterior walls, a pair in the continuous-flow tub room, and one in the pack room. The pumping equipment, including the Leonard Hydriatric valves, for the six continuous-flow tubs remains intact in the side walls of the flow tub room, although the tubs are gone. The pack room originally contained six pack tables, which were on wheels, and these also are no longer present. At the end of the hall is a janitor's closet, which has flooring similar to that of the pool room.

The areas adjacent to the pavilion's courtyards, situated between the original hydrotherapy areas and the wings' patient rooms, each contain two 10-bed patient wards that face out on the courtyards and five 5-bed wards that face out onto the building's side lanai. A central hall runs between the 10- and 5-bed wards, and a community bathroom for the patients is accessed from this hall. The bathroom is situated on the side with the two 10-bed wards. The two 10-bed wards are separated by a wood partition wall, which does not extend to the ceiling. The courtyard-facing wall is dominated by a bank of one-over-one double-hung sash windows with screen transoms, with two doors opening onto the courtyard. A single door with a circular viewing panel accesses the ward from the central hall side.

The 5-bed wards also are entered by single doors with circular viewing panels. Between the first and second wards from the *makai* side is a "quiet room" with its own private bath. A short corridor separates these two rooms and internally connects the second and third wards. A similar configuration exists between the third and fourth wards. Each of the five wards has a set of three one-over-one double-hung sash windows looking out onto the lanai. These have extruded metal screens affixed to the inside of their frames.

The community bathroom has sinks, toilets, and showers. The showers include both private stalls and an open area. The toilet and shower stalls both have gray-veined marble partition walls and wood doors, neither of which extends to the floor. The floors are concrete. The bathroom walls have

a 7-foot 6-inch salmon-colored, glazed tile dado. The men's bathroom also has urinals.

Each wing has a set of concrete dogleg stairs leading to the basement. The stairs are accessed through a pair of double doors, with circular vision panels, off the lateral-running corridors from the lobby. They are situated to the *makai* side of the 10-bed wards, immediately adjoining the wards.

The basement is configured in a U-shaped plan with the rear wall of the stairs encompassed by the rear wall of the basement. The exterior walls of the basement are poured-in-place reinforced concrete, but the basement's interior walls are all hollow tile, except for those directly below the courtyards in the main floor's wings. These four walls are reinforced concrete and essentially enclose dead space, as the courtyards sit on solid earth. The corridor encircling the dead space on the northwest side is referred to on plans as the "treatment corridor" and the corridor on the southeast side is named the "surgery corridor." A lateral-running corridor, with rooms off each side connects the two wings.

The basement flooring is comprised of either 9-inch-square asphalt composition tiles or colored concrete. Ceilings are 10-feet high and plastered. Interior doors off the corridors feature a round vision panel of wire glass. All windows are one-over-one double-hung sash.

Although the building's entry foyer is at the basement level, there is no access to it from the basement. However, the basement may be entered from the outside at three locations: a side door immediately adjacent to the entry foyer on its southeast side, and on the side at either end of the building. The former faces in the southeast direction and is not visible when looking straight-on at the facade. All three entries are solid double doors, and the doorway on the southeast, or surgery side of the basement, is sheltered by a 24-foot 6-inch-long, flat-roofed canopy running out from the building. The canopy is supported by three round concrete columns on each side.

No original plans of the basement indicating room functions have been located. On the northwest side, the corridor encircles the dead space below the courtyard. The six rooms lining the treatment corridors most likely were where various treatments, including electric shock therapy and insulin

treatment, were administered but the specific room for such treatments is unknown.

The functions of a number of rooms off the surgery corridor are more easily comprehended. This corridor is U-shaped with a *mauka* head and parallel legs running along the southeast and northwest sides of the courtyard dead space. Along the *makai* end of the surgery side is the operating room. This room has glazed tile walls and originally had a terrazzo floor, which has been removed to reveal bare concrete. The wall tiles are square and pale gray-green colored. Two doors with large square glass windows in their tops access the room, one from the northwest side corridor and the other from the laboratory. The latter is a swinging door. A set of two stainless steel floor-to-ceiling cabinets with glass double doors dominate the northwest side of the operating room. On the opposite southeast side, a canted window runs almost the entire length of the wall. Behind the window is a viewing gallery, where people could observe surgical procedures. The gallery contains two rows of benches with handrails in front of them. Under the gallery is a small room, entered from a set of concrete stairs that descend from the southeast-side corridor. This room was used to film the operations and has a window that cranks up and down looking into the operating room from below the gallery.

Adjoining the operating room on the northwest side is a laboratory and preparation area. It has stainless steel countertops with cabinets below and hanging cabinets with glass doors above. The walls have a 6-foot 6-inch glazed tile dado, with the tiles the same size and color as the operating room. It has a terrazzo floor. An Amenco sterilizer is built into the wall opposite the swinging door, which leads into the operating room. Two ceramic sinks are also in this area, one to the *makai* side of the operating door and the other in a niche on the *makai* side of the sterilizer.

Immediately *mauka* of the operating room is a clean-up station that includes a sink. Along the southeast-side hall are utility rooms, workshops, a small morgue, and a chiller in which to store decomposable materials.

Most of the finishes in the Goddard Treatment Center (floor, wall and ceiling coverings, doors, windows, and fixtures) are in very poor condition. The building last housed patients in

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1990 and most of the materials show signs of deterioration. Areas of plaster ceiling have collapsed. There is termite damage to most wood work and metalwork is corroding. Most of the equipment that supports the operation of the Goddard Treatment Center (air-conditioning, ventilation, refrigeration, boilers, cooking equipment, etc.) does not appear to be operable. Plumbing, electrical, and telephone systems appear to have also failed. Asbestos remediation has been partially undertaken, as evidenced by the removal of original flooring.

**Historical
Context:**

Goddard Treatment Center was constructed as a major new facility at the Territorial Hospital. Following the United States' admission of Hawaii as the fiftieth state, the building served as an integral element in the Hawaii State Hospital, on which grounds it still stands.

Dedicated in May 1950 and opened for patients in January 1951, the planning for the Goddard Treatment Center was begun at least nine years earlier by then Territorial Director of Institutions, Oscar F. Goddard, and Dr. Ellis A. Stephens, Medical Director of the Territorial Hospital. The \$1.3 million building was "hailed as a milestone in Hawaii's medical history" and "one of the most modern in the nation" when it opened.¹

Sketches, dated September 1941 and titled "Recoverable Unit for Territorial Hospital," are the earliest depictions of the facility that eventually became the Goddard Treatment Center. They show a 204-bed facility that is quite similar in plan to the finished 218-bed building. The most striking difference between the 1941 drawings and the finished building is the roof. The 1941 elevations show a hip roof with gablets which gives the planned building a Hawaiian feeling. This hip roof was omitted on the building when it was constructed and a flat roof put in its place, resulting in a completed building in the International Style. A cost savings was probably realized by this roof substitution, but what was originally envisioned as a more Hawaiian-Style building became an International-Style building with Hawaiian embellishment.

¹ "Milestone in Hawaii's Medical History," *Honolulu Star-Bulletin* (Honolulu, HI), May 22, 1950.

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The decorative elements present on the completed building are the result of the 1947 final drawings for the building by Dickey & Associates. These include the cast stone screens and the grille work in the entry gate and second-story lanai. Also, the curved foyer with modern fluted columns was the result of the later design.

In addition, the plan for the two wings was modified by the addition of the courtyards with a fountain and the expansion of the lanai at the *makai* ends of the wings. Also, the pavilion was added, dividing an originally planned large central courtyard into two courtyards with the pavilion in the middle.

Dr. Stephens and Oscar Goddard both approved the 1941 plans, as did D. F. Balch, Superintendent of Public Works. The plans most likely were developed by the Territorial Department of Public Works in close coordination with Dr. Stephens, for at that time there were no architectural programs developed for mental hospitals. Indeed, across the United States, psychiatrists differed as to what a mental hospital should be, as did hospital administrators. As late as 1947, Owen A. Luckenbach, a partner in the architectural firm O'Dell, Hewlett & Luckenbach of Detroit, noted, "In spite of the need for modern mental hospital facilities, there is as yet no clear formulation of requirements which the architect can follow. He must lead, for there is virtually nothing he may follow."² Similarly, in 1950, Dr. Paul Haun, the chief of the Hospital Construction Unit for the Psychiatry and Neurology Division of the Veterans Administration, advised architects designing psychiatric hospitals to "remember the wisdom of the old recipe for rabbit stew and first catch our rabbit," as there were no medically acceptable construction standards for such buildings.³ Dr. Richard A. Kepner, who was the staff psychiatrist at the Territorial Hospital under Dr. Stevens, noted in the obituary he wrote for Dr. Stephens that Goddard Treatment Center "was finally finished in 1952, exactly according to Dr. Stephens' plans."⁴

Dr. Stephens (1892-1956) was born in Wilkes-Barre, Pennsylvania, and graduated from Wyoming Seminary in 1912 and from Chicago's Loyola University School of Medicine with his MD in 1916. He served in the Navy during

² Owen A. Luckenbach, "Planning the Mental Hospital," *Architectural Record* (June 1947): 107.

³ Paul Haun, "A Program for a Psychiatric Hospital," *Architectural Record* (October 1950): 136.

⁴ Richard D. Kepner, "Ellis Arthur Stephens, M.D.," *Hawaii Medical Journal* (September-October 1956): 56.

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World War I and attended the U.S. Navy Medical School from 1916 to 1917. After the war, he remained on active duty until 1934 and was in charge of psychiatric patients for at least four of those years. Upon retiring from active duty, he traveled and attended graduate school before relocating to Hawaii to work at the Territorial Hospital. He was appointed as the Acting Associate Medical Officer during the terminal illness of Dr. Eckerdt, and, in August of 1937, became the hospital's Medical Director upon Dr. Eckerdt's passing. He held this position until his resignation in 1946.

During his tenure in the position, he worked to further the transition of the Territorial Hospital from a custodial asylum to a hospital offering remedial care. The new concepts and treatment approaches espoused by Dr. Stephens and his staff were embodied in the design of Goddard Treatment Center, and the building is associated with the trend of expanding health care services for the mentally ill in Hawaii. Hydrotherapies, which became popular in the early 1900s, continued to be used, and new treatments were utilized in an attempt to cure the mentally disturbed. New treatments such as insulin shock therapy, electro-shock treatment, pharmacological-shock therapy, neurosurgery, and later electroencephalography, all were introduced during Dr. Stephens' administration.

Hydrotherapy was a commonly used practice, and separate male and female sections were included in Goddard Treatment Center for this treatment. Water was thought to be an effective treatment because it could be heated or cooled and utilized to elicit different reactions. Continuous-flow warm water baths were used to treat patients suffering from disorders such as insomnia and for calming excited and agitated behavior, as well as suicidal and assaultive tendencies. In this approach, patients were confined to tubs enclosed by a canvas top with a hole for the head. Patients, depending on the severity of their condition, were immersed in continuous flowing warm water for a matter of hours or up to several days, being only allowed out to relieve themselves. Goddard Treatment Center had separate rooms for this treatment, as well as pack rooms. With the pack treatment, patients were tightly wrapped in sheets dampened by varying temperatures of water, and they would be strapped down to a table in this condition for several hours. Those exposed to such cold water (48 to 70 degrees Fahrenheit) packs were often diagnosed as manic-

depressive or exhibiting signs of excitement and excessive motor activity. Separate rooms at Goddard Treatment Center, adjacent to the continuous-flow tub rooms, were reserved for this treatment. Both of these treatments required attendants to be on hand over long time periods to administer the treatment, and when confronted with staffing shortages, these programs were often phased out in favor of electro-shock or psychiatric drug treatments.

The Territorial Hospital was at the forefront of adapting a number of new innovations that became popular throughout the nation in the 1930s and 1940s, all of which had special treatment rooms in the basement of Goddard Treatment Center. These included insulin-shock therapy, electro-shock therapy, and neurosurgery.

Convulsive shock therapies started to be employed at the hospital in 1938 when pharmacological shock was introduced at Kaneohe to treat dementia praecox, via the drug metrazol. Developed in 1934 by the Hungarian-American neurologist and psychiatrist Ladislas J. Meduna, professionals in psychiatrics learned of his studies with the publication of his book in 1937, which claimed a 50% success rate with schizophrenics. When metrazol was injected into a patient, it produced an explosive seizure about a minute after injection. Often the convulsions resulted in broken bones and torn muscles. For effectiveness, it was given two to three times a week, with a complete treatment running thirty to forty injections. *The Department of Institutions Annual Report for 1940* noted, "The use of pharmacologic shock therapy was continued with good results in many cases but with disappointing results in others. Towards the latter part of the year, pierotoxin as a convulsive agent was used but it is too early to comment on the results."⁵ These convulsion-inducing drugs were used for only a few years before they were supplanted by electroconvulsive therapy (ECT), popularly called electro-shock therapy.

Electro-shock therapy was developed in 1938 by Italian neuropsychiatrists Ugo Cerletti and Lucio Bini. The method used electric shocks applied to the brain to produce seizures in patients suffering from schizophrenia, major depressive order, mania, and catatonia. In 1940, this treatment was

⁵ *The Department of Institutions Annual Report for 1940*, 3.

introduced at the Territorial Hospital, and favored over pharmacologic shock therapy as it was deemed to be a simple technique that was inexpensive and resulted in minor complications. The shock and convulsion were easily controlled, and as patients were anesthetized prior to subjecting them to the electro-shock therapy, staff did not have to endure the strong resistance that they unsurprisingly encountered when trying to administer the drug-induced shock therapy. A special room was included in the basement of Goddard Treatment Center for this treatment. In the United States, ECT devices came into existence prior to medical devices being regulated by the Food and Drug Administration (FDA), so the FDA was obligated to retrospectively review already existing devices and classify them, and determine whether clinical trials were needed to prove efficacy and safety. While the FDA has since classified the devices used to administer ECT as Class III medical devices, it has not yet determined whether the devices should be withdrawn from the market until clinical trials prove their safety and efficacy.

Insulin shock therapy was another treatment employed at the Territorial Hospital, having been introduced after World War II. Viennese physician Manfred Sakel started to develop insulin shock therapy in 1927 after he accidentally gave one of his diabetic patients an insulin overdose, which sent her into a coma. The woman, a drug addict, woke up and declared her morphine craving gone. Sakel began to experiment with other patients and in 1933 reported a 90% recovery rate, particularly among schizophrenics. *The Department of Institutions Annual Report* for 1947 noted the expanded use of insulin-coma therapy at the Territorial Hospital, especially in “the management of acute cases of schizophrenia, which is the largest single problem in a mental hospital.”⁶ A special room in the basement of Goddard Treatment Center was dedicated to this treatment. Worldwide, the popularity of insulin therapy faded during the 1950s, mainly because it was dangerous, with between 1% and 2% of treatments resulting in death.

Neurosurgery, in the form of lobotomies, was also a treatment employed at the Territorial Hospital. This procedure was developed in 1936 by the Portuguese doctor Egas Moniz, who believed mental illnesses were generally

⁶ *The Department of Institutions Annual Report* for 1947, 87.

caused by problems in the neurons of the frontal lobe, the part of the brain just behind the forehead. Moniz believed the technique could cure insanity while leaving the rest of the patient's mental function relatively normal and his research seemed to support that. Although this treatment was controversial since its inception, it remained a mainstream procedure for more than two decades, and in 1949, Moniz was awarded the Nobel Prize for Physiology or Medicine.

The first lobotomy conducted at the Territorial Hospital occurred in 1942. It was applied only to chronic patients who were deemed to have incurable disorders of five or more years and who had failed to respond to other treatments. Familial consent was obtained prior to undertaking the operation. Lobotomies were one of the procedures undertaken in Goddard Treatment Center's operating room. By 1945, close to 100 of these operations were performed in Kaneohe, with 38 operations alone in 1945. Throughout the United States, 1949 proved to be a peak year for lobotomies when 5,074 procedures were undertaken, and by 1951, over 18,608 individuals had been lobotomized throughout the nation. However, as the number of lobotomies increased, a major problem became apparent. The patients weren't just calm; they were virtual zombies who scarcely responded to the world around them. The treatment soon fell out of favor, and in 1950, a drug named chlorpromazine (sold as Thorazine) was introduced as a means of altering human behavior. Over the ensuing years, other mood-altering drugs were introduced, revolutionizing the treatment of mental illness and leading to the abandonment of many of the practices of the previous decades.

Although we now recognize many of the above forms of treatment as archaic and mostly ineffective, Dr. Stephens also introduced such cutting edge practices as individual and group psychotherapy, psychiatric nursing, occupational therapy, a liberal policy of home visits, and the hiring of a psychiatric social worker to oversee recreational therapy, which included the establishment of a beauty salon, the holding of dances, the showing of motion pictures, and organized picnics. The expansion of the recreational program is seen in the inclusion of the pavilion in the 1947 plans for the Goddard Treatment Center with its movie

projection room and recreation area, and the inclusion of a room specifically designed as a beauty salon. During non-mealtimes the cafeteria was used for group psychotherapy.

Thus, the Goddard Treatment Center and its modern design embody what was then the most advanced thinking in the curing of mental illness. It is very much associated with the pattern of events and changing attitudes that are important to the history of the treatment of the mentally ill in Hawaii.

Doubtless, the United States entry into World War II, three months after the date of the 1941 drawings of the treatment center, put construction efforts on hold until the late 1940s. During the war, the Territorial Hospital buildings in Kaneohe, which were constructed during the 1930s, were used by the military. Several wooden barracks-type buildings were built, but no other construction was undertaken between the late 1930s and the construction of Goddard Treatment Center. Oscar F. Goddard died in February 1944, and Dr. Stephens resigned in 1946, as the hospital was underfunded and understaffed, resulting in over-crowding and malnutrition among the patients.

A December 1946 report compiled by Thomas B. Vance, the Director of Public Institutions, and members of the hospital staff, including Dr. Stephens' successor, Dr. Marcus Guensberg, described the "appalling conditions" at the hospital, with "disproportionate congestion" making the wards "indescribably terrible." While the hospital had transitioned itself to operate as a modern treatment center, it was hampered by the budget of a custodial system. As a result of the negative publicity engendered by the report, monies were appropriated in early 1947 to increase the operating budget of the hospital and to design and construct a recoverable patients unit, which would become the Goddard Treatment Center. The architectural firm of C. W. Dickey Associates prepared construction plans dated November 1947. Charles Dickey, a major proponent for appropriate regional architectural design for Hawaii, had died in 1942, and the firm that bore his name was taken over by William Merrill (Dickey's nephew), James Simms, and Kenneth Roehrig, who in 1948 began listing the firm under their own names.

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The building was built in the International Style, which was very popular in Hawaii and most of the rest of the world during the late 1940s through the 1980s. The flat roof with its overhanging simple cornice line, bands of windows and grilles, and smooth unadorned wall surfaces are characteristics of the International Style expressed in this building. Aside from being an International-Style design, there are some local details that were often used during the period to mark the building as up-to-date but also Hawaiian: cast-stone grilles in a floral motif at the entry, decorative metal grilles in a geometric motif at the entry and *makai* ends of the patient wings, courtyards to provide open space and bring the outdoors into the building, and various means to try to make the building work as a naturally ventilated structure.

The new building accommodated 218 patients and was used to house and evaluate new admissions. The *Star Bulletin* described it as,

A beautiful two-story building built about an open courtyard, it looks more like a tourist hotel than an institution... Huge windows give patients a view of the sea or mountains from nearly every room... The hospital is just as secure as an old-fashioned jail-type institution, says Director Marcus Guensberg. But open recreation areas in the center of the building nearly eliminate the sense of confinement.⁷

In addition to the previously mentioned treatment rooms in the building, a room was also dedicated to the electroencephalograph, which was used to help diagnose incoming patients and mark their progress.

It is important to note that the Goddard Treatment Center was not only a new building at the Territorial Hospital, but a new type of building. If the hospital's only need was to provide more living space this could have been accomplished following the lines of the buildings constructed during the 1930s. Instead, a new treatment and reception center was desired, a building which embodied the current thought on the treatment and curing of the mentally ill. As

⁷ "New Hospital for Mentally Ill Will Rank with Top Institutions," *Honolulu Star-Bulletin* (Honolulu, HI), Aug. 27, 1949.

such, the new hospital building conformed to the prevailing design thinking for mental hospitals.

As a building type, mental hospitals were a relatively new architectural program. While hospitals have been constructed since ancient times, there were no buildings specifically built to treat the mentally ill until the end of the eighteenth century, with the insane placed in prisons or poor houses prior to that time. In France, Phillippe Pinel advocated moral treatment of the insane based on humanitarian ideals, and in 1793, removed the chains from the mentally ill in the Bicetre in Paris. At the same time in England, William Tuke began treating the insane in a similar manner and advocated that asylums be built in bucolic environments to aid in a person's recovery. His York Retreat became a prototype emulated decades later in the United States.

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In the 1840s, Dorothea Dix became a strong advocate for the humane treatment of the mentally ill in America, and Dr. Thomas Story Kirkbride (1809-1883), the superintendent of Pennsylvania Hospital for the Insane, incorporated such ideals into mental hospital design. Dr. Kirkbride was one of the thirteen founding members of the Association of Medical Superintendents of American Institutions for the Insane (AMSAIL), the forerunner of the American Psychiatric Association. He served first as secretary, then later as president of this organization. Through this association and in his writings, Kirkbride promoted a standardized method of asylum construction and mental health treatment, popularly known as the Kirkbride Plan, which significantly influenced the entire American asylum community during his lifetime. He built on Pinel and Tuke's ideas of moral treatment, and the positive role buildings and grounds played in the treatment of the insane. The institutions he proposed were placed on extensive grounds with cultivated parks and farmland, with the patients housed in one large masonry building with a central administrative core flanked by separate wings for men and women. Various illnesses were separated by floors, with the more excited patients placed on lower floors and the quieter patients on upper floors. Sunlight and fresh air were important elements in designing the building, and patients were housed in private rooms rather than wards. Patients were encouraged to help work the farms and keep the grounds, as well as participate in other chores. Such structured occupation was meant to provide a

sense of purpose and responsibility, which it was believed would help regulate the mind as well as improve physical fitness. Patients were also encouraged to take part in recreations, games, and entertainments, which would also engage their minds, make their stay more pleasant, and perhaps help foster and maintain social skills.

Toward the end of the nineteenth century, however, the Kirkbride Plan lost prominence in the system that it played such a major role in developing. A lack of concrete evidence indicating substantial numbers of permanently cured patients, and no reduction in the incidence of mental illness, caused the mental healthcare establishment to seek different ways of handling the insane. Cost considerations led insane asylums to become primarily custodial institutions rather than remedial. Although many existing Kirkbride buildings continued as important parts of state hospitals well into the twentieth century, the imposing brick and stone buildings gave way to an asylum based on a cluster of separate cottages, where the sexes and various illnesses could be housed in separate ward buildings that allowed for the separation of noisy and violent patients from the other charges. By the start of the twentieth century, the cottage plan came to dominate the field of asylum design.

Early cottage plan buildings were typically no more than two stories tall, and they were typically built of fireproof materials such as brick, stone, and slate. Each cottage was purposely built for a single type of patient, and there were typically two sets of buildings for each, one for women and one for men. Hospital campuses usually resembled a college with large, well-manicured lawns, flower beds, trees, fountains, and other decorative items. Typically, an administration building was located at the front of the campus, and patient buildings would encircle the campus with communal buildings such as a kitchen, chapel, or auditorium in the center. Power plants, laundry facilities, and farms were often located to the rear of the campus. When Honolulu's insane asylum was relocated in 1929-1930 from School Street to Kaneohe where it was renamed the Territorial Hospital, the cottage plan was followed. As an emphasis was placed on confinement rather than treatment, these buildings often served as dormitories and offered little in the way of private rooms or space devoted to treatment.

With the shifting emphasis on remediation, rather than confinement, doctors and administrators at the Territorial Hospital had to try to accommodate changing needs within the existing physical plant. When an opportunity arose to consider constructing a new building, their highest priority was on a modern center that would meet the evolving needs of the profession. The Goddard Treatment Center incorporated elements from both the cottage and Kirkbride plans. Sited at the rear of an existing cottage complex, it retained the one- to two-story scale which had come to dominate twentieth century asylum design. However, the building was organized in the manner of the Kirkbride Plan with a central administrative core flanked by male and female wings. Serving as a reception and treatment building, it functioned in a manner that corresponded with Dr. Paul Haun's discussion of such a building:

Patients will be admitted first to this building for detailed examination, classification and intensive therapy. Patients with favorable prognosis will be treated here for periods of four to six months in the hope that a return to the community can be effected without the necessity of transfer to other wards of the hospital... Patients from this building will make full utilization of facilities in the auxiliary treatment buildings: recreation, occupational therapy, gymnasium, and theater. Patients with unfavorable prognosis whose improvement under active treatment is improbable will be transferred within short periods to an appropriate building in the chronic hospital zone for long term therapy.⁸

Unlike the building described by Haun, Goddard Treatment Center housed a gymnasium and theater in the form of the pavilion, and offered recreation and occupational therapy within the building. Like other new hospitals of the time, such as the receiving building at Anoka, one of Minnesota's state mental hospitals, Goddard Treatment Center's designers strove to isolate the new patients from the hospital's general population in an effort to give the new patient every chance at a cure.

⁸ Haun, "A Program for a Psychiatric Hospital," 139.

In 1953, Alston G. Gutterson, the U.S. Public Health Service's Hospital Architect, explained the importance of the reception and treatment building,

It is the receiving and intensive treatment building, more than any other building of the modern mental hospital, that offers the best opportunity for a discussion of the facilities required in modern treatment programs for nervous and mental patients. It is the building all the new patients will come for their initial diagnosis, and, in the majority of cases, will remain for treatment until return to the community can be effected...

The receiving and intensive treatment facility, more than any other service of the modern mental hospital, reflects the changing attitude and treatment of nervous and mental patients... It has facilities for the segregate housing and treatment, in small groups, of all types of patients; for their diagnosis, for their occupation and recreation. This modern service encourages, also, a greater freedom for a greater percentage of patients. The modern mental hospital does not reflect secure custody, but rather a simplified and controlled community in which constructive activity has been substituted for deteriorating inactivity or destructive behavior.⁹

The inclusion of courtyards in the Goddard Treatment Center may be viewed as an attempt to instill a sense of Hawaii into the building. This may very well have been the intention, as the courtyards in the wings and the pavilion with its monitor roof, as well as the decorative elements on the façade, were all introduced late in the design process by Dickey & Associates. However, other mental hospitals built during the period in warm climates also offered outdoor interactions within their confines through the use of roof terraces and upper floor sun decks, as exemplified by the Rosary Clinic, DePaul Sanitarium in New Orleans and the Norton Memorial Infirmary in Louisville, Kentucky. Similarly, the Treatment

⁹ Alston G. Gutterson, "Design of Intensive Treatment Buildings," *Architectural Record* (November 1953): 189.

Building in Salem, Oregon designed by Pietro Belluschi includes a rooftop solarium.¹⁰ Also, the Receiving Building at the Psychiatric Hospital in Rio Piedras in Puerto Rico featured a courtyard. However, the absence of patient dayrooms, a standard feature in the above mentioned hospitals, appears to indicate that Goddard Treatment Center more extensively used the courtyards, pavilion, and the lanai at the end of its wings as centers of activity more so than the other hospitals.

The centralization of the administrative staff in Goddard Treatment Center was also a common practice of the time, although some states favored that the medical staff be decentralized to be in closer proximity to the patients they worked with on a regular basis. This area of the building closely correlates with Guttersen's description of this area in an ideal mental hospital,

The administrative offices are grouped together in a separate area near the main entrance, convenient to the public and away from diagnostic and treatment areas. The main elements of this administrative group are: main entrance lobby and waiting room, information counter, public toilets, public telephone, business office, medical record room, library and conference room, offices for chief psychiatrist, chief psychologist, chief psychiatric social worker, chief nurse, secretaries and admitting, personnel lockers, toilets, and janitor's closet.¹¹

The inclusion of treatment areas in the building also was considered best practice as well:

The intent in the receiving building is that it furnish diagnosis and treatment of new patients for return to the community without their having been a part of the main mental hospital population. Since receiving buildings having this service are relatively new, their pattern of requirements has not been clearly established.

¹⁰ Haun: 127, 131, 142-145, 150.

¹¹ Guttersen, "Design of Intensive Treatment Buildings," 192.

This is particularly true regarding the amount of diagnostic equipment which is to be included in this facility.

Analysis of the treatment program establishes the fact that duplication of routine diagnostic equipment in the total hospital is justified in many instances.¹²

Similarly, the location of these treatment rooms in the basement was considered advisable:

Diagnostic facilities should be grouped together and away from areas of patient activities... In addition, facilities for insulin and electric shock treatment will be required in the receiving building... Insulin may be given, as is preferred by some, in the single room of the patient. It is usually given in a larger room where several patients may receive the treatment at some saving in staff.¹³

Guttersen also pointed out the insulin room might also be used as a recovery room for persons given electro-shock treatment, as this recovery time was usually around thirty minutes.

The presence of an operating room in Goddard Treatment Center, however, was not considered the norm, as Guttersen deemed one such facility was sufficient to serve a hospital complex. Most likely, the Territorial Hospital's facility for this purpose was deemed inadequate and one was included in Goddard Treatment Center in order to upgrade this aspect of hospital service. The canopied walkway leading to the surgery wing seems to indicate these rooms served the entire hospital and not just patients in Goddard Treatment Center.

The inclusion of a kitchen and cafeteria separate from that used by the main hospital also followed the intention of not mixing Goddard Treatment Center's patients with those of the general population of the hospital.

¹² Ibid., 193.

¹³ Ibid., 194.

The pavilion also was designed in accord with best practices of the period, as,

*The exercise gymnasium should be a minimum of approximately one half of a basketball court for installation of a basketball backboard and basket. In general the least competitive activities will be used, though volleyball, badminton, shuffleboard, and ping-pong may be among the activities scheduled. Punching bags, tumbling mats, parallel bars, exercise pulleys, etc. are some of the equipment that will be used. The space should be arranged so that it will be used for motion pictures, plays and dances. The gymnasium should open to outdoor exercise areas where tennis and ball games may be organized.*¹⁴

The placement of the continuous flow baths and pack rooms adjacent to patient rooms was also recommended, and, “since continuous flow bath treatments cannot be scheduled, there must be two separate tub rooms where men and women patients are being treated.”¹⁵

The Goddard Treatment Center was designed and constructed near the end of a period that emphasized a variety of treatments for the curing of mental illness. Within a few years of its completion, psycho-pharmaceutical drugs were discovered and this changed the entire complexion as to how the medical professions would deal with mental illness.

The building stands as a reminder of the beginning years when the treatment philosophy for the mentally ill in Hawaii shifted from confinement to focus on curing and discharging patients. The new treatments, used during the 1930s through the 1950s, were thought to show great promise; however, they were soon eclipsed with the introduction of drug therapy. The Goddard Treatment Center has not been used to house patients since 1990.

¹⁴ Ibid., 195.

¹⁵ Ibid., 209.

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Sources: The Department of Accounting and General Services contains a number of original drawings relating to Goddard Treatment Center's original design and construction, as well as subsequent alterations. The following sources provided information used in the preparation of this report.

Date	Title	Architect	Drawing Location
9/12/1941	Floor Plan	Not signed	DAGS File C-11-3
9/12/1941	Basement Floor Plan	Not signed	DAGS File C-11-3
9/12/1941	Elevation	Not signed	DAGS File C-11-3
9/12/1941	One Half Floor Plan B	Not signed	DAGS File C-11-3
12/3/1947	Sheet 1 Plot Plan	C. W. Dickey Associates	DAGS File C-11-3
12/3/1947	Sheet 9 Main Floor Plan Left Half	C. W. Dickey Associates	DAGS File C-11-3
12/3/1947	Sheet 12 Elevations	C. W. Dickey Associates	DAGS File C-11-3
12/3/1947	Sheet 19 Kitchen	C. W. Dickey Associates	DAGS File C-11-3
12/3/1947	Sheet 33 Basement Floor Plan	C. W. Dickey Associates	DAGS File C-11-3
	Sheet A-1 Renovation of Kitchen in Goddard Building	Wilson Okamoto	DAGS File C-11-4

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**Project
Information:**

The Hawaii State Department of Health proposes to demolish Goddard Treatment Center, which has been abandoned since 1990. In accordance with Chapter 6E, Hawaii Revised Statutes, the Department of Health has consulted with the Hawaii State Historic Preservation Officer (SHPO) and other parties, and has agreed to document the building in accordance with HABS standards prior to undertaking the proposed demolition. This photo documentation and recordation fulfills that agreement.

The photographic documentation was undertaken by David Franzen, photographer. Dr. Don Hibbard, Alison Chiu, and Mayu Ohama, Architectural Historians at Fung Associates, Inc. who meet the Secretary of the Interior's qualifications, prepared the written documentation.

Date of Report: November 14, 2014